Stress in undergraduate medical education: 'the mask of relaxed brilliance'

THE adverse effects of professional life on the health of doctors and their families have caused disquiet for many years.[1,2] Concerns have been heightened recently by the introduction of the new general practitioner contract[3] and the wider health service reforms.[4] Walton has described the physical and mental conditions to which doctors and their families are at risk.[2] These include drug dependence (psychotropic and addictive drugs) and alcoholism as well as increased rates of suicide and domestic problems when compared with the general population. Pressure from work is unavoidable in medical practice and O'Dowd has highlighted the features of the burn out that it may cause.[5] These include outbursts of irritation and anger as well as feelings of tiredness and anxiety. Such pressure can result in a detached and cynical approach to patients, and so can compromise the quality of care.

Medical education fails to prepare doctors for dealing with the stresses that they will encounter later in their careers. Indeed, it can compound these through the conditioning of inappropriate responses to stress. The pressures of the postgraduate years have been well documented in a number of studies.[6-10] Many of these are now being addressed in order to achieve a proper balance between service and training,[11] with greater commitment to education from senior medical staff and more reasonable working hours for junior hospital doctors.[12,13]

Unfortunately, by the time young men and women begin postgraduate education their abilities to recognize and to cope with professional stress will have been eroded by their undergraduate experiences, as was demonstrated recently in the BBC television series, *Doctors to be.* Now attention must be directed to lessening the causes of stress in undergraduate medical education if we are to retain the commitment and enthusiasm with which students begin their undergraduate days. That so many complete medical school feeling cynical, weary and disappointed is an indictment of the system that they have endured.[14]

In most medical schools, the environment itself is an all prevailing pressure providing an authoritarian and rigid system; one that encourages competition rather than cooperation between learners.[15] The inadequacies of personal supervision and the lack of a clearly discernible role for students reinforce this. Against such a background there are more overt causes of stress, including what Silver and colleagues have described as 'medical student abuse'.[16,17] Its commonest form is verbal attack, through insults, ridicule, or harsh or unjust statements. A common manifestation is public humiliation by senior doctors on the ward round or during the case presentation when the victim is mocked about lack of knowledge or experience. This is one of the most damaging and stressful aspects of medical education. Since students look to their teachers as models to emulate, it is hardly surprising that such abusive behaviour is perpetuated from one generation to the next.

Working in such a system, an individual's sense of priorities becomes introspective rather than altruistic, with endurance becoming the prime aim. In this way, emotions are suppressed and so begins the development of the emotionally aloof, distant and unapproachable professional with what Coombs and colleagues have described as 'the defensive facade of calm, self assured achievement; the mask of relaxed brilliance'.[18] The expression of feelings or the admission of ignorance becomes difficult. The 'stiff upper lip'[19] emerges, together with an unrealistic belief in their own invincibility.[2] In these circumstances, an explicit request by a doctor for help becomes unthinkable: and so the questioning and challenging approach to learning that is essential for self education as well as sound clinical practice becomes suppressed.

The prompt implementation of the proposals from the General Medical Council's education committee,[20] which are echoed in Angela Towle's King's Fund study,[21] would soon lead to substantial improvement in the ability of young doctors to cope with stress. Both have emphasized the urgent need to lessen the knowledge overload of undergraduate education: knowledge that is acquired simply for the sake of passing the next test. This is poor preparation for medicine and, as a recurring pressure, dampens enthusiasm for learning and the enjoyment of acquiring, for oneself, new knowledge and fresh skills.

Medical schools need to create imaginative opportunities for students to learn for themselves so that a critical and enquiring approach to education can be encouraged; one that will sustain doctors throughout their professional lives. Such a philosophy is not new. It was embodied in the Goodenough report on medical education that was published in 1944.[22] This stated that the main emphasis in medical education 'should be on the inculcation of fundamental principles and methods rather than on the implanting of a mass of purely factual knowledge'. It also emphasized that the organization of medical student education should allow 'for the full and active participation of the students so that their education proceeds as much by their own efforts to learn as by their teachers' to instil knowledge into them'. It is sad that almost 50 years later too few medical schools have recognized the importance of these views in the development of their curricula.

As education becomes more self directed the teacher's role should be to provide support, guidance and feedback about progress. In this way, the usefulness of not knowing something will come to be appreciated, for it will form the basis for future learning. A greater emphasis on participative and collaborative learning, for example in small groups and through shared projects, will enable students to help each other not only to learn, but also to cope with the unavoidable pressures of medical school life.

The fundamental key to future success will be the teacher–student relationship, for in many ways it provides a model of the future doctor–patient relationship. Goodenough recognized that the quality of those who taught medical students would be crucial for improvements in medical education.[22] He observed that 'in the past too little attention has been paid to the training of the teachers of medical students'. Teaching must be accorded a higher value in medical schools, with recognition that the day of the amateur teacher has passed. Elton and Partington have developed criteria for identifying and rewarding the effective university teacher.[23] These should be adapted for the selection and reselection of medical student teachers, and continuing appointment should depend upon meeting them. Through the development of a cadre of sensitive, able and enthusiastic teachers working with medical students in a stimulating and supportive environment, we shall develop future doctors who are sensitive to their patients' and to each others' needs and who will be better able to cope with the inevitable pressures of their future practice.

The nature of general practice and the interpersonal skills of many general practitioner undergraduate teachers enables them to make substantial contributions to the pastoral care of medical students as well as to the clinical curriculum.[24,25] The need for more medical student teaching to take place in the setting of general practice is increasingly recognized as more and more patient care takes place entirely in this context.[20,21] This will enable general practitioner teachers to help future doctors to appreciate the importance of recognizing and coping with the stresses that they encounter in their professional lives, and to develop the skills needed for this at an earlier stage in their careers than happens at present. More appropriate methods of undergraduate education could help prevent the damaging effects of burn out later in a doctor's career.

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General practice in deprived areas: problems and solutions

THE *Health of the nation* identifies key areas and targets for improvement of health.[1] All the causes of preventable ill health and premature death mentioned are most prevalent in deprived areas. However, the provision of health promotion clinics and their use by patients is lower in such areas.[2-5] To produce changes in attitude and behaviour among people in these deprived areas requires commitment from a wide range of health and community workers operating together to achieve agreed objectives.[6]

Building an effective primary care team in areas of poverty represents a considerable feat of ingenuity usually brought about by a small number of motivated health care professionals. If the team is successful personal rewards can be high. However, mobility of staff can lead to instability within practices, and recruitment and retention of doctors and staff are major problems in such areas.[7,8] Some district health authorities do not recognize the importance of practice attachment of nursing staff, and few make sufficient allowance for the additional workload health visitors carry in deprived areas compared with those working in more affluent communities.[9] General practitioners from deprived areas should be employed by health authorities on a sessional basis to provide advice on health policy. In particular, they could draw attention to workload implications and needs based on attainment targets.

Difficult problems require practice staff of high calibre. To overcome recognized recruitment problems it may be necessary to offer reimbursement of staff salaries at higher levels than the current 70%, even 100% in some circumstances. An extension of the role of primary care facilitators, and concentration by them on deprived areas would raise the profile of these issues at the level of the family health services authority, enabling justification of resource diversion.

The focus on competition between practices in the new contract for general practitioners,[10] with income highly sensitive to changes in list size, offers little help to general practitioners or their patients. Whether doctors with smaller lists give better care